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BOARD OF REVIEW

# ADMINISTRATION OF JUSTICE IN THE PROVINCIAL COURTS OF ALBERTA

REPORT No. 1

## THE CORONER SYSTEM IN ALBERTA

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# BOARD OF REVIEW

Provincial Courts

## REPORT No. 1

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## BOARD OF REVIEW

Provincial Courts

Mr. Justice W. J. C. Kirby, Chairman
Dr. M. Wyman
J. E. Bower, Esq.

J. L. Lewis, Esq., Counsel
D. S. Ross, Esq., Secretary

# BOARD OF REVIEW

## OPERATION OF PROVINCIAL COURTS

REPORT No. 1

## CORONERS

Item 4 — Whether any changes should be made in the practices and procedures presently being followed in the offices of the Coroners and with respect to inquests?

Item 5 — Whether any changes should be made to The Coroners Act?

Item 6 — Whether Coroners should receive some initial and continuing training in their duties?

To His Honour,
The Lieutenant Governor of the
Province of Alberta.

May it please Your Honour:

Having been appointed by Order-in-Council a Board of Review under *The Public Inquiries Act* to review the operation of the Provincial Courts and to report thereon, we submit Your Honour Report No. 1 with respect to items 4, 5 and 6 of the terms of reference.

March 25, 1974.

Chairman

Member

Member

Approved and Ordered, O.C. 867/73

Edmonton

LIEUTENANT GOVERNOR June 5, 1973

**WHEREAS** it is expedient and in the public interest to have a review of the administration of justice in the Provincial Courts of Alberta:

**THEREFORE**, upon the recommendation of the Honourable the Attorney General, the Lieutenant Governor in Council by these presents, nominates, constitutes and appoints, pursuant to the provisions of The Public Inquiries Act, a Board of Review consisting of MR. JUSTICE W. J. C. KIRBY, Calgary, of the Trial Division of the Supreme Court of Alberta, DR. M. WYMAN, President of the University of Alberta, Edmonton, and J. E. BOWER, Editor of the Advocate, Red Deer, members, with MR. JUSTICE KIRBY as Chairman, to review the operation of the Provincial Courts and to report thereon to the Lieutenant Governor in Council and in particular to review and report on

1. what should be the respective roles and relationships of the Provincial Judges, the Prosecutors, the Clerks of the Court and the Police in the administration of justice in these Courts;
2. whether any changes should be made in the administration of justice in the Juvenile and Family Courts and if so, what should be the respective roles of the Judges, Lawyers, Court Counsellors, Probation Officers, Clerks of the Court and other officers and officials of those Courts;

3. what changes, if any, should be made in the practice and procedures used in obtaining search warrants and the handling of the material seized;

4. whether any changes should be made in the practices and procedures presently being followed in the offices of the Coroners and with respect to inquests;

5. whether any changes should be made to The Coroners Act;

6. whether Judges and Coroners should receive some initial and continuing training in their duties;

7. whether it would be desirable to appoint a Chief Provincial Judge or Senior Judges and if so, what should be their duties;

8. whether any changes should be made in the system of establishing or operating Circuit Courts;

9. whether the Provincial Judges presently presiding in the Provincial Courts of Edmonton and Calgary should travel on circuit and whether the Provincial Judges presiding in rural areas should from time to time sit in the Provincial Courts in urban centres;

10. whether the present practice of allowing Provincial Judges in rural areas to deal with juvenile offenders is desirable or necessary;

11. whether any changes should be made in the procedures followed in the enforcement of maintenance orders in the Family Courts or in any of the other procedures of those Courts;

12. whether lawyers of the Juvenile and Family Courts should act for either side in dispute matters;

13. whether any changes should be made in the procedures followed by the Clerks of the Provincial Courts in the performance of their administrative duties;

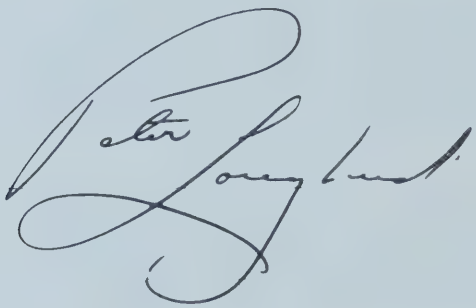
14. whether present facilities in remote areas provide satisfactory judicial services;

15. whether the present system of issuing Warrants of Committal against persons who default in payment of fines for provincial offences is desirable or necessary and if so, whether any changes should be made in the processing or enforcement of such Warrants;

16. whether the present system of levying fines against persons convicted of traffic offences should be continued and if not, whether a Traffic Violation Report System similar to that in use in the Province of British Columbia should be adopted;

17. whether it is desirable to treat infractions of municipal by-laws as offences in Provincial Courts and whether the collection of penalties provided for in by-laws for such infractions should be effected in the Small Claims Court or some other court of civil jurisdiction;

18. such other matters as may be deemed relevant by the Board of Review in order to ensure a full and fair inquiry and to enable it to make a report and such recommendations as it deems fit.



CHAIRMAN

## ACKNOWLEDGMENTS

The Board has been greatly assisted by Mr. J. L. Lewis, Counsel to the Board. We are grateful to Mr. D. S. Ross, Secretary to the Board for the efficient manner in which he has attended to administrative arrangements. We acknowledge the services of Mr. Stanley Carscallen, who has rendered valuable assistance in research and summarizing transcripts of the hearings.

The Board expresses thanks to the Deputy Attorney General and the officials in his Department for the assistance and co-operation which has been accorded at all times; to the Clerks of the Court in Grande Prairie, Red Deer, Edmonton, Calgary, Lethbridge and Medicine Hat for providing facilities for public hearings; to the official Court Reporters who have provided accurate transcripts of the public hearings.

We express appreciation to the Deputy Attorney General of Manitoba for permitting Thor Guttormson, Esq., Administrator of Court Services for the Province of Manitoba to appear before the Board and review the operations of the Manitoba *Fatality Inquiries Act*.

We acknowledge the benefit of reference to the Report of the Royal Commission Inquiry into Civil Rights in Ontario, 1968, and the Report of the Ontario Law Reform Commission on the Coroner System in Ontario, 1971.

## PROCEEDINGS OF THE BOARD

Following constitution of the Board, notification of the times and places of the hearings, and a copy of the terms of reference were sent directly to the following:

All Provincial Court Judges including the Juvenile and Family Court Judges;

Members of the Legislative Assembly of the Province of Alberta;

The President of the Provincial Judges Association of Alberta;

The President of the Law Society of Alberta;

The President and Executive Director of the Alberta Medical Association;

The Vice-President for Alberta of the Canadian Bar Association;

The Presidents of the Local Bar Associations in Peace River, Edmonton, Central Alberta, Calgary, Lethbridge and Medicine Hat;

The Chief Coroner and all Coroners in the Province of Alberta;

The Director of the Institute of Law Research and Reform;

The Dean and all members of the Faculty of Law at The University of Alberta;

The Clerks and Sheriffs of the Supreme Court, District Court and Provincial Courts within the Province of Alberta;

The Director of the Legal Aid Society of Alberta;

The Officer Commanding "K" Division of the R.C.M.P. in Alberta and all officers in charge of R.C.M.P. detachments in the Province of Alberta;

All agents of the Attorney General;

All members of the Law Society of Alberta;

The Director of Student Legal Services at The University of Alberta;

The Chiefs of Police in Peace River, Grande Prairie, Edmonton, Camrose, Wetaskiwin, Drumheller, Central Alberta, Calgary, Lethbridge and Medicine Hat;

The Wardens or Keepers of all correctional institutions in the Province of Alberta;

The Secretary-Treasurer of all Counties or Municipal Districts in the Province of Alberta;

The President of all Chambers of Commerce in Alberta;

The Alberta Federation of Police Associations;

The Human Rights and Civil Liberties Association;

The Social Workers Association;

The Indian Association of Alberta;

The John Howard Society of Alberta;

The Metis Association of Alberta;

The Alberta Motor Association;

The Alberta Hospital Association.

Hearings were held at the following places on the dates shown:

| | | |
|---|---|---|
| Grande Prairie | — | October 15th |
| Red Deer | — | October 18th |
| Edmonton | — | October 22nd-26th |
| Calgary | — | November 12th-16th |
| Lac La Biche | — | November 28th |
| St. Paul | — | November 29th-30th |
| Lethbridge | — | December 3rd |
| Medicine Hat | — | December 6th |

Written briefs with respect to items 4, 5 and 6 were submitted by the Alberta Medical Association, the Civil Liberties subsection of the Canadian Bar Association, the Human Rights and Civil Liberties Association, the Indian Association of Alberta, the Saddle Lake Indian Band, the Blackfoot Reserve, the City of Calgary, the Grande Prairie Daily Herald Tribune, the City of Edmonton, Foothills Provincial Hospital, and the Division of Pathology, Faculty of Medicine of the University of Calgary.

In addition to hearing the representatives of the foregoing organizations, the Board heard oral submissions from Dr. M. M. Cantor, Provincial Chief Coroner, from Bernard Brosseau, M.D., a Coroner and John E. E. Morgan, M.D., a Coroner and from repre-

sentatives of the Grande Prairie Bar Association, Edmonton City Police, the Medicine Hat Bar, and others.

Chapter 2 of the Craig report was filed for reference.

Thor Guttormson, Esq., Administrator of Court Services for the Province of Manitoba appeared before the Board and discussed the operation of the Manitoba *Fatality Inquiries Act*.

Further hearings will be held as follows:

| | | |
|---|---|---|
| Calgary | — | April 8th-11th |
| Edmonton | — | April 16th-20th |
| Fort Macleod | — | April 29th-30th |
| Wetaskiwin | — | May 2nd-3rd |
| High Level | — | May 6th-7th |
| Peace River | — | May 9th-10th |
| Slave Lake | — | May 13th-14th |
| Fort McMurray | — | May 16th-17th |

## HISTORICAL BACKGROUND

The origins of the common law office of Coroner are historically obscure. Together with the office of Sheriff the office of Coroner is one of the most ancient institutions in English legal and constitutional history.

The word Coroner is thought to be derived from the old French word "corune" or "Coroune," meaning crown, and may have evolved from the term "crowner" meaning representative of the crown.

The office of Coroner is first historically documented around the end of the 11th century during the time of William the Conqueror, and owed its original existence to the considerable revenues which accrued to the crown in the event of sudden or unexplained death. It was the primary duty of the Coroner at that point in history to secure these revenues for the King.

The first detailed statute on the office of Coroner was the Statute of Westminster, in 1275. The powers and duties of the Coroners were specifically prescribed by the statute *De Officio Coronatoras* of 1276 (4 Edw. I. stat. 2). By a statute of 1487 (3 Hen. VII c. 1) a fee was established to be paid to the Coroner for each inquest. By that time the office had evolved from one primarily concerned with the collection of revenues for the crown to one charged with the investigation of deaths which occurred by violence or unnatural means.

A significant feature of a review of the historical evolution of the office of Coroner is the fact that the general function of the office of investigating sudden or unexplained deaths has not substantially changed over the ages.

Historically Canada inherited the concepts of a Coroner and of a Coroner's inquest as part of the common law, the implications of which are considered in the Report on the Coroner System in Ontario of the Ontario Law Reform Commission, 1971, which considered the recommendations of the Inquiry into Civil Rights conducted by the Honourable J. C. McRuer.

The common law power of a coroner, to indict persons upon an inquisition for murder and manslaughter and to commit them for trial, to certify the evidence, and to bind over material witnesses by recognizance, were incorporated as part of the federal criminal law in 1869, and remained in effect until the introduction of the first

Criminal Code in 1892 in which the indictment function of the inquest was terminated. The report points out that while the 1892 Code terminated common law ties between the office of coroner and the criminal law which had existed for centuries, the severance between coroners and the criminal law was not complete.

By virtue of section 462 of the Criminal Code R.S.C. 1970 C-34 where a person is alleged by a verdict of a coroner's inquisition to have committed murder or manslaughter, but has not been charged with the offence, the coroner is required to issue a warrant for the arrest of that person or to require him to enter into a recognizance and to transmit the evidence to a justice.

Coroners are also required by provisions in the Criminal Code to hold an inquest on the body of a person executed under the death penalty.

The report states:

> If the coroner's inquest is the same type of institution in Ontario as the 'coroner's court' in England, which 'unquestionably is in England' a 'criminal court of record', then the Legislative jurisdiction to prescribe procedural rules relating to a great many of the coroner's functions would lie with Parliament and not with the Legislative Assembly of Ontario. (1)

The report refers to the case of *Wolfe v. Robinson* (2) a decision of the Ontario Court of Appeal in which it was held that the coroner's court is a court of criminal record and only the Parliament of Canada has authority to enact legislation as to the rules of practice and procedure to be followed in that forum.

This view was rejected by the British Columbia Court of Appeal in E.v. *McDonald Ex. p. Whitelaw* (3).

The report commented on these decisions in these words:

> The judgment of each Court of Appeal is not entirely free from doubt. In the absence of an authoritative decision upon these questions by the Supreme Court of Canada, it is not possible for the Commission to undertake an analysis which would be any more useful than the simple observation that there is a basic disagreement among some of the most skilled jurists in Canada upon the constitutional position of the coroner. (4)

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(1) Report page 11.
(2) *Wolfe v. Robinson* (1962) O.R. 132 (C.A.).
(3) E. v. *McDonald Ex. p. Whitelaw* (1969) 2 DLR (3d) (B.C.C.A.).
(4) Report page 16.

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## THE CORONERS ACT

The first *Coroners Act* in Alberta was enacted in 1906 Statutes Chapter 15.

The Act was brief. It has since been frequently amended and revised to its present form in The Revised Statutes of Alberta 1970, Chapter 69.

The original Act did not provide for the appointment of a Provincial Chief Coroner, a provision which was not made until 1927.

The present Act provides that the powers, duties and remuneration of the Provincial Chief Coroner shall be such as are from time to time defined and set forth by Order of the Lieutenant-Governor in Council, but action has not been taken to implement this provision. The present Chief Coroner has been remunerated for his services by way of retainer fees.

In 1972 Dr. M. M. Cantor the present Provincial Chief Coroner, who has served in that capacity for twenty-four years following nineteen years as deputy Chief Provincial Coroner, prepared a draft for a proposed new *Coroners Act* in which the duties of the Provincial Chief Coroner would be codified. He has prepared and provided to coroners throughout the Province a manual setting forth their powers and duties.

There are now 156 coroners in Alberta. In 1973, 237 inquests were held in the Province at a total cost including indirect expenditures of about one million dollars.

Dr. Cantor provided the Board with a report outlining the circumstances under which inquests have been held, as well as those under which autopsies are performed, and suicides or suspected suicides investigated.

He filed a draft of a proposed new *Coroners Act*, prepared by him, in which among many other changes, the functions, powers and duties of coroners at common law would be repealed and their functions, powers and duties would be codified.

## LEGISLATION IN OTHER PROVINCES

In 1960 the Province of Nova Scotia enacted a statute entitled *The Fatality Inquiries Act*, applicable to the City of Halifax and the Town of Dartmouth, to replace *The Coroners Act*. *The Coroners Act* continued to be applicable to the counties.

In 1960 the Province of Prince Edward Island enacted a statute entitled *Death Inquiries Act* to replace *The Coroners Act*. This Act has not yet been proclaimed.

In 1970 the Province of Manitoba enacted a statute entitled *The Fatality Inquiries Act* to replace *The Coroners Act*. The Act was proclaimed on February 1st, 1971.

This Act was similar in concept to *The Fatality Inquiries Act* enacted in Nova Scotia and Prince Edward Island.

The significant feature of all these Acts is the division of responsibilities into the medical and legal disciplines, the initial inquiry into the cause and manner of death being carried out by a duly qualified medical practitioner, and the inquest, when deemed necessary, being carried out by a magistrate. In both Acts, the jury is eliminated.

## SUBMISSIONS

The brief submitted by the Alberta Medical Association pointed out the difficulty of presenting a consensus of all 2,300 members of the Association, the opinions received being quite diverse. It acknowledged that there was a strong feeling that the Act and the statement of the duties of coroner should be modified, but suggested further detailed study before definitive action is taken. It requested that the Association be given the opportunity to review any proposed changes in *The Coroners Act*. Specifically it suggested that the medical examiner system used widely in the United States, be studied with the view to its possible implementation here. Aspects of this system referred to favourably, were the separation of the investigative and judicial functions, the encouragement of the training and recruitment of physicians with special expertise in forensic medicine, the use of qualified medical practitioners as medical examiners to undertake whatever examinations or investigations were necessary to determine the cause of death, and to report to a higher authority who would determine what action, if any, should be taken.

The brief pointed out that the Association had recommended to the Government that autopsies be required by the coroner in all cases where death occurred within 72 hours following the performing of surgery, and that they had been given to understand that the major obstacle to the implementation of this recommendation was that sufficient funds were not available. The brief recommended that resources be made available for this purpose.

Some members of the Association objected to the provisions of section 24 (2) of *The Coroners Act*, by which anyone who has been charged or is likely to be charged with an offence relating to the death being inquired into, is entitled to the protection afforded by the *Canada* and *Alberta Evidence Acts* but is not excused from answering any question on the grounds that his answer to the question might tend to incriminate him. The objection was on the grounds that these provisions undermine the rights of an individual to a far greater extent than our present society should tolerate. It was suggested that persons giving evidence during a coroner's inquest, especially those who might ultimately be prosecuted in a criminal action, should have the same privilege of testifying that they have in criminal proceedings.

As an alternative, it was suggested that all witnesses at a coroner's inquest be automatically given the protection of the *Evidence*

*Acts*, and, as a lesser alternative, that it be insured that all witnesses prior to their giving evidence be notified of the protection available to them under these Acts.

The Civil Liberties subsection of the Canadian Bar Association recommended that more industrial accidents be inquired into.

They recommended that, in the conduct of inquests, evidence be introduced by legally trained counsel and not by police officers; that interested persons be entitled to be represented by counsel; that the practice of the cause of death being written out in advance by the coroner and the function of the jury thereby reduced to that of adding a rider, be discontinued; that the medical practitioner or pathologist who certified the death be required to appear at the inquest for examination and cross-examination.

They proposed that where police are involved in a death in a blameworthy fashion, the investigation should be carried out by an independent authority.

They also expressed concern over the provisions of section 24 (2) of *The Coroners Act* whereby a person who is suspected of causing a death being inquired into or who has been charged or is likely to be charged with an offence relating to the death shall not be excused from answering any questions on the ground that his answer to the question might tend to incriminate him, as abrogating or altering the existing rule which protects a person charged with crimes from being compelled to testify against himself.

The submission by the Alberta Human Rights Association criticized the practice of a police officer representing the Crown at inquests and conducting the examination and cross-examination of witnesses, pointing out that section 24 (4) of *The Coroners Act* only provides for counsel appointed by the Attorney General to perform that duty. The brief stressed the need for stricter adherence to evidentiary rules. In this connection it questioned the practice of a coroner entering the time, place, and cause of death on the form of inquisition summing up a jury's verdict, pointing out that it is the function of the jury to determine these matters, on the basis of the evidence it has heard. It also stressed in this connection the importance of calling the pathologist who has performed an autopsy to give *viva voce* evidence at an inquest as to the cause of death. The pathologist should be subject to examination and cross-examination.

The brief deplored the infringement of civil liberties inherent in proceeding with an inquest when there is a likelihood of criminal

charges being laid with respect to the death being inquired into; in the frequent failure of coroners to inform witnesses of the protection afforded by the *Evidence Acts* against self incrimination; and in coroners failing to inform a witness of his right to be represented by counsel who may examine and cross-examine witnesses.

The brief suggested that the Chief Coroner's office should direct itself to matters of social concern, citing, as examples, the drinking driver on the highway, and death arising from taking drugs. It stressed the desirability of the accumulation of statistics relating to causes of death.

The Association recommended that *The Coroners Act* be codified, and that coroners be provided with a Code of Ethics.

The submission on behalf of native Indians stressed special problems of particular concern to them, arising out of the operation of *The Coroners Act*. It attributed these problems to particular circumstances which apply to the Native people such as: the fact that many of them, especially those covered by Treaty No. 8, live in remote areas lacking both in amenities and proper avenues of communication; the fact that they lack comprehension of the nature and function of the office of coroner; and, the fact that they have different cultural values.

The delegates appearing on behalf of Saddle Lake Band No. 125 felt that accidental deaths occurring on Indian Reserves were not always investigated and that when they were investigated, families concerned were not always informed of the results of the investigation. They recommended that an inquest involving the death of an Indian be held on the Reserve on which the deceased lived and that if the preliminary investigation by the coroner did not result in an inquest, that the family of a deceased should be informed of the results of the investigation and the reasons why an inquest was not being held.

Similar views were expressed in the submission on behalf of the Blackfoot Reserve in which the suggestion was advanced that where a post-mortem examination was being considered on the body of a deceased Indian, the family of the deceased should be consulted before it was carried out. An alternative proposal in this connection was that an independent committee be created for the purpose of determining whether post-mortem examinations should be performed and whether an inquest should be held. They criticized the predominant part played by police in the selection of a jury for an

inquest and suggested that Indians selected for a coroner's jury inquiring into the death of an Indian, should not be from the same Reserve as the deceased.

They recommended that coroners should have initial and continuing training relating to their duties.

They felt that the investigations of unexplained deaths or deaths occurring in suspicious circumstances on Reserves were often carried out by the police in an offhand manner, and that there was too much active participation by the police in the conduct of inquests.

The Indian Association of Alberta is the official representative of 42 bands comprising some 40,000 members. In its brief, the Association pointed out that in Treaty No. 8 area, comprising the northern part of the province, the great distances, the remoteness of many Reserves, poor means of communication, all create particular problems.

It was felt that there are many unexplained deaths of native Indians and that because of poor communications between the police and coroners, investigations of these deaths were often not carried out. It was suggested that the coroner's office have an investigative arm attached to it, staffed by officers having special training and having authority similar to that of a police officer. Such an independent investigative arm would be of particular value in a situation where a police officer was involved in the death being investigated.

Concern was expressed over deaths occurring on Indian Reserves owing to faulty wiring in homes, substandard housing and heating. It was felt that in such instances inquests should be held in order to focus public attention on these problems so that they could be rectified. This it was said, was not being done.

The Association criticized the prominent part played by police in the conduct of inquests, in preparation for the hearing, notifying witnesses, arranging for juries and in some instances transporting the coroner during the actual conduct of the hearing. This involvement of the police, it was said, is being viewed with suspicion by the Indian people and particularly impaired the credibility of an inquest in cases where police are involved in the death being inquired into.

The practice of a coroner speaking to the jury concerning its recommendations was criticized.

It was suggested that the conduct of an inquest be in the hands of a provincial judge or other person having legal training and that the function of the coroner be confined to presenting the results of his investigation into the cause of death and the surrounding circumstances.

Native Indians are particularly sensitive with respect to the treatment accorded bodies of deceased natives. This arises from the fact that a dead person is still a person to them. They asked for respect for these beliefs by those carrying out an investigation into the death of an Indian, and specifically that the family of a deceased person to whom a body is being returned after an investigation or inquest be given prior notification of the arrival of the body; that the body should be shipped in a manner of befitting dignity; and that, where a post-mortem examination has been performed, techniques be employed which leave the body in a condition least offensive to the family of the deceased.

The need for better communication between the police and native Indians was stressed, and it was suggested that one way in which this could be met was through establishment of close contact with Band Councils.

The City of Calgary drew attention to the fact that the coroner in deciding whether an inquest is to be held, and in presiding at the inquest, is acting in a judicial capacity with little or no training. It questioned the continued utilization of non-legal personnel in that capacity, and stated further that when he conducts the examination or cross-examination of witnesses, the coroner endangers his impartiality in his judicial capacity.

It questioned the provisions of section 24 (1) of *The Coroners Act* with respect to self-incrimination and suggested that the protection afforded by the *Evidence Acts* be automatic. It objected to the procedure on inquests in Calgary of handing out a summary of investigative reports prior to witnesses being examined and their evidence put on record.

The City criticized the practice of juries on inquests going beyond their function of inquiry, that of inquiring as to when, where and by what means a deceased came to his death and the tendency of many coroners to regard the inquest as being in the nature of a trial, resulting in questions being asked intended to prove criminal or civil liability.

It was suggested that juries are often not properly instructed with respect to adding riders to their verdict and in some instances are told by a coroner the rider which in his view should be added.

The City recommended that consideration be given to enacting legislation similar to that introduced in Manitoba, known as *The Fatality Inquiries Act*; that with respect to the evidence of any witnesses who may be the subject of a criminal charge, the inquest be adjourned until determination of that charge; that in all major cities, Crown counsel should be present to examine all witnesses at an inquest; that the right of other counsel to cross-examine witnesses be restricted, and that if provincial judges are utilized for conducting inquests, they have discretionary power to limit cross-examination to what is reasonably necessary for the purpose of the inquest. The use of a jury found no support.

The submission on behalf of the Foothills Provincial Hospital and the Division of Pathology, University of Calgary, suggested that the *Coroners Act* should be considered in conjunction with *The Vital Statistics Act*, so far as the registration of deaths is concerned. It criticized the mechanism provided for under *The Vital Statistics Act* by which a funeral director is the channel of communication in the registration of deaths between the Registrar of Vital Statistics and the medical practitioner who was last seen in attendance during the last illness of a deceased, or the coroner who conducted an inquiry on the body or into the circumstances of the death, or an inquest. It suggested that the registration of a death should properly be the responsibility of the next-of-kin of the deceased.

The submission also recommended that if a doctor is not available, no burial permit should be issued without a coroner's consent and then only after the coroner is satisfied that he knows the cause of death; and that public institutions should not be permitted to hand over bodies to funeral directors without a proper authorization in the form of an acceptable death certificate or disposal order.

It suggested further that the qualifications of coroners be defined, and, specifically, that newly qualified doctors or lawyers should not be appointed.

It criticized section 7 (1) of *The Coroners Act* as being vague as to whether death from industrial disease is a "natural death" in the accepted sense, and it was suggested that it might be better to state definitely that sudden or unexpected death is a cause for investigation.

It also questioned the necessity of the provision in section 7 (2) of *The Coroners Act* requiring notice to the Provincial Chief Coroner of a death occurring in a hospital within 30 days of an operation.

Section 9 (1) of *The Coroners Act* requires the coroner, if he deems an inquest unnecessary, to forthwith transmit to the Director of Vital Statistics, all information and particulars required under *The Vital Statistics Act*, including the cause of death. The submission recommended that registration of "natural causes" should not be permitted in the rare cases where no cause can be determined after investigation.

Other recommendations contained in the submission were that the circumstances under which notice of death is given to a coroner under section 13 (1) of *The Coroners Act* should be extended to include deaths of mental patients detained against their will, and deaths of foster children or any child in the custody of welfare authorities; that the provisions of section 17 of *The Coroners Act* should be rewritten to cover all industrial accidents; that post-mortem examinations should be carried out where possible by a pathologist; that the coroner in major centres should have an office provided together with secretarial assistance and a plainclothes officer permanently attached to carry out initial investigations; that the number of coroners in large areas should be reduced to one with one deputy; that there should be two trained forensic pathologists, one in Calgary and one in Edmonton, who should undertake to perform all autopsies in all cases where suspicion of foul play is suspected, to be funded by the Attorney General's Department but employed through the University in order to establish public confidence that they are independent.

In a supplementary brief, Dr. John C. Butts, Associate Professor (Pathology) of the Faculty of Medicine, University of Calgary, recommended that a medical practitioner who has been in attendance on a deceased prior to his illness be required by law within 24 hours of the death to send a certificate of death stating (a) that he has attended the dead body of the deceased; (b) that he certifies to the fact of death; and (c) what the cause of death is if he knows it. He further recommended that if the practitioner cannot give such a certificate or if the death is unnatural, he should be obliged to report the case directly to a coroner or medical examiner; that the circumstances under which a coroner or medical examiner would be notified of a death be more precisely defined and such notification be made mandatory.

The brief suggested that three medical-legal specialists on a full-time basis are needed in Alberta, that a public morgue should be located adjacent to a major hospital so that the facilities of that hospital in histopathology, radiology and possibly toxicology could be used; that both Calgary and Edmonton urgently require a full-time coroner and permanent supporting staff.

Mr. Thor Guttormson, Administrator of Court Services for the Province of Manitoba appeared before the Board and discussed the operation of the Manitoba *Fatality Inquiries Act*. The most notable feature of this Act, replacing *The Coroners Act*, is the division of responsibility into the medical and legal disciplines, by having the initial investigation carried out by a duly qualified medical practitioner in his capacity under the Act of a medical examiner, and the public inquiry, when deemed necessary, being conducted by a magistrate without a jury.

A letter written by the former Deputy Administrator of Court Services for Manitoba in 1972 produced by Mr. Guttormson described the new Manitoba Act as a substantial improvement on *The Coroners Act* and recites some of its merits in these words:

> 1. The Medical Examiner does not conduct the hearing of the formal inquest as this has been assigned to the Magistrate who is much more qualified to hold a hearing and same is held by the Magistrate in the same manner as he would hear any other case.
>
> 2. Dispensation of a Coroners' Jury has not only shortened the length of formal hearings, but also done away with Coroners' Jury verdicts respecting civil liability which was never the responsibility of the Coroners' Jury and at times was in error.
>
> 3. Separation of the functions of a sudden death and assignment of same to the people most capable to perform same, namely; the investigation to the Police, the medical aspects to the Medical Practitioner, and the formal hearing to a legally trained Magistrate; whereas under the old Coroners' system the Coroner was required to perform all three functions.
>
> 4. Centralization of all Inquiries in the Office of the Administrator of Court Services has enabled us to keep detailed statistics and classifications of the types of sudden deaths occurring throughout the Province.
>
> 5. The appointment of a Chief Medical Examiner and the supervision of all the Medical Examiners by both the Chief Medical Examiner and the Administrator of Court Services is enabling us to bring about uniform guidelines in determining whether or not a formal Inquest should be held.

6. The dual supervision of the Medical Examiners by both the Chief Medical Examiner and the Administrator of Court Services not only has upgraded the abilities of the Medical Examiners but will also enable us to institute programs of continuing education through annual seminars, etc.

# OBSERVATIONS

## OBSERVATIONS

Although the death of a person is often a traumatic experience for the friends and relatives of the deceased, society should look upon death as a normal process, and society should provide simple procedures that will enable burial or cremation to take place within a few days after a death has occurred. Having said this, it is important to go on to say that agencies of a provincial government must be empowered to gather information concerning all deaths that take place within that province. Some information may have legal importance. Some information may have medical importance. There always exists the possibility that statistical information, accurately stating the cause of death, may be valuable in research efforts designed to protect and prolong human life.

*The Vital Statistics Act* provides the means for compiling this information. It establishes the procedure for registration of death which requires information being furnished as to:

(1) the identity of the deceased;
(2) the time and place of death;
(3) the cause of death.

In the Province of Alberta, about 80% of all deaths take place in a hospital. An even greater percentage of deaths will now occur with a physician in attendance at the time of death, or immediately prior to the death. Under such circumstances, the information listed above is usually easily, accurately, and quickly obtained. When this information has been established, the interest of agencies of government should normally cease, and burial or cremation should be allowed to take place.

However, the public has a legitimate interest in deaths that occur other than through natural causes, which raise such questions as:

(1) what was the cause of death?
(2) did the death occur because of the wrongful behavior of one or more persons?
(3) did the death occur because of the malpractice or negligence of one or more professionals?
(4) was the death preventable or avoidable?
(5) does the death require a post-mortem examination to establish the medical cause of death?

(6) did the death occur when the deceased was involuntarily detained in the custody of some agency of society?

In such circumstances, an initial investigation is called for by a properly qualified person, endowed with the necessary authority to determine the facts as to how, when, where and by what means such a death occurred. The logical person to determine these facts is a qualified medical practitioner.

The finding of this investigation may well be death with no untoward circumstances, death due to criminal behavior, death due to malpractice or negligence, and so on. Normally this information should be given to the appropriate agency of government, and that agency should be responsible for any further action that might be indicated.

On the other hand, this initial investigation may indicate the need for further inquiry, which we suggest could take three different forms: (1) a detailed scientific investigation; (2) a detailed police investigation; and (3) a public inquiry.

### (1) Detailed Scientific Investigation

In deaths that occur as a result of a crash, or some other form of disaster, the cause of death, as it would be described in medical terms, is usually obvious. It is far more important to seek answers to questions like, "What was the cause of the crash?" or "What was the cause of the disaster?". Indeed, answering such questions may well be important, even if no deaths are involved.

In any event, questions of this type should be asked of professional people who are competent to give meaningful and useful answers. When one considers the highways, the airways, and the thousands of quite different industries, all with their potential for accidental death, it is difficult to see the wisdom of attempting to design an omnibus act that would provide for the carrying out in a reasonable way of all of the different scientific investigations that might be required. Some investigations might be of a research nature, carried out on a continuing basis by a permanent staff of government. Other investigations might be of short duration, and in such investigations a single outside professional consultant might provide the answers to the questions that should be asked. Still others might be of long duration, and might require a variety of professionals using a multitude of technologies to establish why this or that accidental death took place. Although provincial legislation should

provide procedures by means of which all of these investigations could be carried out, the legislation should not be contained in one act. For example, a highway act should contain the procedures by means of which highway deaths are investigated, and a mines act should contain the procedures for investigating accidental deaths that take place in mines. We have heard no evidence that leads us to believe in the existence of one, and only one, procedure broad enough to provide for the investigation of all the accidental deaths that might befall people who work or play under hazardous conditions.

### (2) Detailed Police Investigation

If the initial investigation points to a death having been caused by criminal behavior of any person or persons, then the matter should be turned over to the police for further investigation and appropriate action.

### (3) Public Inquiry

Some people have argued with considerable validity, that all investigations under a *Coroners Act* should end with the detailed medical investigation. They believe that coroners' inquests do not provide adequate protection for those who are required to appear and give witness at inquests, that such inquests are frequently abused by lawyers seeking information for civil suits, and that, at best, such inquests rubber stamp the professional opinions gathered by detailed medical investigations. Although we have heard representations that convince us that the number of public inquiries can and should be drastically reduced, we do not believe they should be abandoned.

In some instances the initial investigation does not succeed in establishing the cause of death. When a person is held in involuntary detention in a public institution, those who work in the institution are entrusted with the protection and preservation of the life of that person. When, under such circumstances, a death occurs, malicious rumors often arise that neglect of duty played a major role in that particular death. For the protection of all concerned, we believe a public inquiry to be the best means of dispelling the rumor or determining actual neglect of duty. A public inquiry may also be a good way to make public the fact that some of our facilities to protect and preserve human life are inadequate by modern standards.

The Ontario Law Reform Commission Report summed up the primary functions of an inquest, emphasizing its value

> . . . as a means for public ascertainment of facts relating to deaths, as a means for formally focusing community attention on and intiating community response to preventable deaths, and as a means for satisfying the community that the circumstances surrounding the death of no one of its members will be overlooked, concealed or ignored. (1)

We accept these as the proper functions of a public inquiry.

An examination of the present *Coroners Act* reveals that part of the act is obsolete, part of it may well be *ultra vires*, and all of it should be rewritten to meet the needs of a modern society that has advanced technologies at its disposal. In order to make a complete break with the past we suggest that it be repealed and replaced by an act to be known as *The Fatality Inquiry Act*; that the terms "Chief Provincial Coroner", "coroner", and "coroner's inquest", be respectively replaced by the terms "Supervisor of Medical Examiners", "medical examiner", and "public inquiry".

An inquiry under the proposed act would involve a formal hearing in which witnesses would be examined under oath. Since this would call for knowledge on the part of the presiding official of the Rules of Evidence, and might result in criminal charges being laid, or give rise to civil litigation, it should preferably be conducted by a person with legal training. In our view he should be a Provincial Judge. The submissions we have heard have convinced us that juries can play no significant role in such an inquiry.

We deem it fundamental to the conduct of the inquiry that it not be used as a step in criminal proceedings or as a means of obtaining information for civil litigation.

We agree with the view expressed by the Ontario Law Reform Commission that it can find

> . . . no practical justification for the position that the coroner's inquest should continue to be viewed as being such an integral part of the criminal process that the power to legislate in relation to its procedure should be within the exclusive jurisdiction of the Parliament of Canada. The classification of "court of criminal record" for an inquest is historical rather than functional, and has outlasted both its accuracy and its utility. (2)

We feel that the doubt as to the constitutional position of the coroner, referred to earlier in this report, would be resolved by repeal of *The Coroners Act*, and with it of the common law applicable to

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the office of coroner in Alberta, and by enactment of a *Fatality Inquiry Act*.

It is by no means clear to us that evidence given at inquiries held under provincial legislation, even though the protection of *The Canada* and *Alberta Evidence Acts* has been explicitly invoked, can be withheld from a court created by federal legislation.

A modern *Fatality Inquiry Act* should reflect the function, purpose, philosophy and policy intended by the legislation. It should name the people who will administer the Act, and should state the powers they will exercise. Nevertheless, such an Act should not be too detailed. It is envisaged that regulations will accompany such an Act; that details of procedure may change from time to time, and will be set forth in the regulations, not in the Act.

Questions 4, 5 and 6 of the terms of reference pose these questions:

4. whether any changes should be made in the practices and procedures presently being followed in the offices of the Coroners and with respect to inquests;
5. whether any changes should be made to the Coroner's Act;
6. whether Judges and Coroners should receive some initial and continuing training in their duties.

We answer "Yes" to the first two questions. Our recommendations follow.

# RECOMMENDATIONS

## RECOMMENDATIONS

The Board recommends with respect to item 5 of the terms of reference:

1. That *The Coroners Act* be repealed and be replaced by an Act to be known as *"The Fatality Inquiry Act"*.
2. That the common law so far as it relates to coroners and lies within the jurisdiction of the Legislative Assembly of the Province of Alberta, be repealed.

We make the following recommendations with respect to item 4:

1. That the new Act be administered by a Supervisor of Medical Examiners appointed by the Lieutenant-Governor in Council.
2. That the Supervisor of Medical Examiners serve on a full-time basis and be paid an annual salary commensurate with his responsibilities.
3. That qualified medical practititioners be appointed medical examiners for such areas or districts as may be designated by the Lieutenant-Governor in Council, and that two or more medical examiners be appointed for each hospital in which there are two or more medical practitioners on the staff, all to have province-wide jurisdiction.
4. That the medical examiners be appointed by the Lieutenant-Governor in Council on the recommendation of the Supervisor of Medical Examiners, after consultation with the Alberta Medical Association.
5. That the powers and duties of the Supervisor of Medical Examiners and of the medical examiner be expressly defined in the Act.
6. That the Supervisor of Medical Examiners shall supervise the medical examiners in the performance of their duties under the Act and shall have all the rights and powers of a medical examiner.
7. That the Supervisor of Medical Examiners shall be responsible to an official of the Department of the Attorney General designated by the Minister.
8. That the Supervisor of Medical Examiners shall, subject to the approval of the Lieutenant-Governor in Council, prepare a Code of Ethics and regulations for the use and guidance of medical examiners.

9. That a copy of every death certificate shall be forwarded to the Supervisor of Medical Examiners as soon as possible following a death.

10. That the circumstances under which a medical examiner is to be notified of a death be precisely defined in the Act, and that such notification be mandatory.

11. That these circumstances include, in addition to those provided for in section 13 (1) of *The Coroners Act*, the decease of
    - any person who was an involuntary inmate of any institution in the Province;
    - any child in a foster home or otherwise in the care and custody of welfare authorities.

12. That after a medical examiner has carried out an investigation into a death, he shall submit a report to the Supervisor of Medical Examiners and shall recommend whether or not a public inquiry should be held.

13. That the Supervisor of Medical Examiners, in consultation with an official of the Attorney General's Department designated by the Attorney General, may direct that a public inquiry into a death be held, and that, if the Supervisor of Medical Examiners does not direct a public inquiry, the Attorney General may, in his discretion, do so.

14. That a public inquiry into a death shall be conducted by a Provincial Judge, without a jury.

15. That a public inquiry shall not be ordered when criminal charges have been laid.

16. That, if during an inquiry the judge becomes aware that a criminal charge has been laid in connection with the death, or has reasonable grounds for believing that a criminal charge may be laid, he shall adjourn or abandon the inquiry.

17. That, subject to control by the presiding judge, any person who, in the judge's opinion, is substantially and directly interested in the inquiry, may be represented by counsel with power to call, examine, and cross-examine witnesses.

18. That the statement in the Manitoba *Fatality Inquiries Act* concerning the giving of evidence be included in the *Alberta Fatality Inquiry Act*. (1)

19. That a post-mortem examination, to be performed wherever possible by a pathologist, may be ordered by a medical examiner, the Supervisor of Medical Examiners, or by the Attorney General.

20. That the medical examiner who has conducted an investigation into a death, and the medical practitioner who has conducted a post-mortem examination, shall normally be required to testify in person at an inquiry and be subject to cross-examination.

21. That in the conduct of an inquiry, evidence shall be adduced by an attorney for the Crown.

22. That police participation in an inquiry shall be limited to that of being witnesses.

23. That upon completion of an inquiry the presiding judge shall make his findings public, and submit a report to the Attorney General who will act on it as he sees fit.

24. That provisions of *The Coroners Act* applicable to the carrying out by a medical examiner of his duties under *The Fatality Inquiry Act* be incorporated in the Act or regulations.

With respect to item 6 of the terms of reference: it is not considered necessary for a medical examiner to have any special training additional to his professional qualifications as a medical practitioner.

The Board further recommends:

1. That in determining whether or not a post-mortem examination is to be conducted, the religious beliefs of the family of the deceased be considered.

2. That proper respect be accorded religious beliefs in the handling of the bodies of deceased persons on whom post-mortem examinations are to be performed or have been performed.

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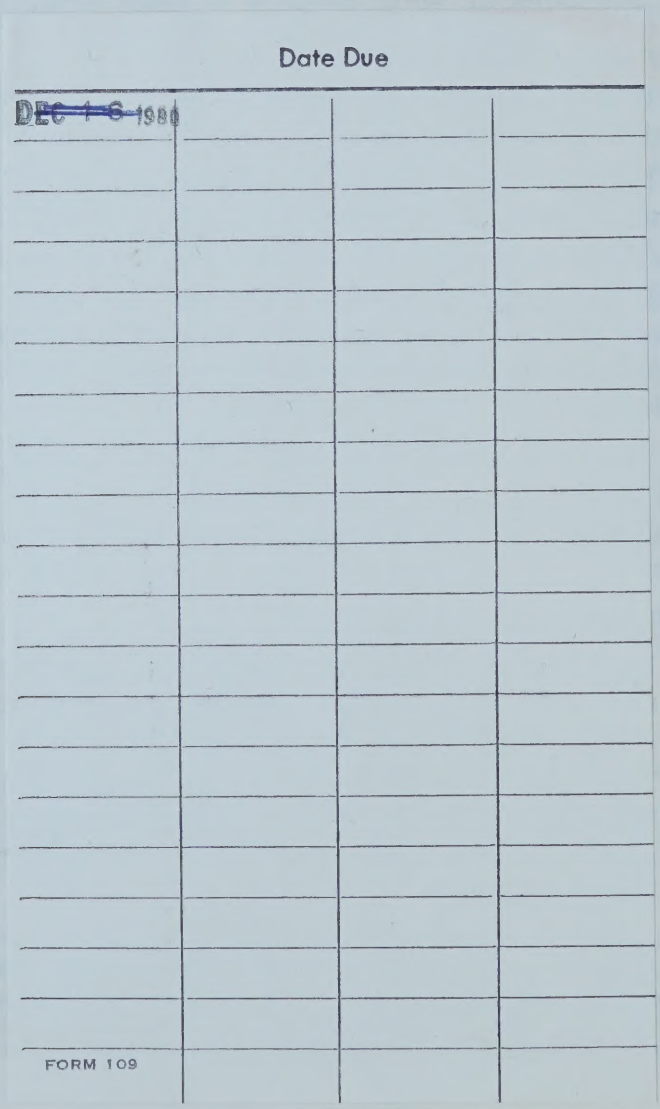
(1) The statement is that "A witness giving evidence at the inquiry shall conclusively be deemed to have objected to answer every question put to him upon the ground that his answer may tend to incriminate him or to establish his liability in a legal proceeding at the instance of the Crown or of any person".

3. That consideration be given to the recommendations in the submissions of the Foothills Provincial Hospital and the Division of Pathology, Faculty of Medicine, University of Calgary, with respect to the procedure for registration of deaths and issue of burial permits under *The Vital Statistics Act*.

4. That steps be taken to set up records designed to afford statistical information pertaining to the results of investigations of medical examiners, the findings by presiding judges in inquiries, and causes of death reported in registrations of death.

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